

Envoy Medical Systems, LP
4500 Cumbria Lane
Austin, TX 78727

PH: (512) 836-9040
FAX: (512) 491-5145

Notice of Independent Review Decision

DATE OF REVIEW: 8/27/12

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

RT shldr arthroscopy, MUA, capsular release, distal clavicle excision, bicept tenodesis, cortisone injection; CPT: 29824, 29825, 29828, 23700, 20610; Outpatient

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION

Physician Board Certified in **Orthopaedic Surgery**

DESCRIPTION OF THE REVIEW OUTCOME THAT CLEARLY STATES WHETHER OR NOT MEDICAL NECESSITY EXISTS FOR EACH OF THE HEALTH CARE SERVICES IN DISPUTE.

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

Upheld	(Agree)	X
Overtaken	(Disagree)	
Partially Overtaken	(Agree in part/Disagree in part)	

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Adverse Determination Letters. 7/25/12, 7/11/12
Peer Reviews, 7/24/12, 7/10/12,
Physician Advisor Referral, 7/20/12
Clinical/Follow-up Notes 7/2/12 - 1/26/12; 11/29/11 - 8/16/11
Radiology Rpts, Rt MRI & comparison, 1/24/12; 10/14/10
Operative Rpts., 4/09/12, 9/26/11, 7/08/11,
ODG Guidelines

PATIENT CLINICAL HISTORY SUMMARY

Patient had a work related fall. There was a follow up MR arthrogram suggesting a partial tear with tenolysis. Patient has had a physical therapy program and an extensive amount of care, injections, surgery, etc. and looking at her history, apparently continues to have pain. The patient's symptoms are apparently aggravated by daily activities.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION

I would agree with the benefit company's decision to deny the requested services since the patient has had an extensive amount of postoperative care, physical therapy, injections, medications, etc. Patient has had at least three, and possibly four, surgical procedures. The operative reports provided were from 7/08/11 at

which time the procedure was described as a rotator cuff repair, acromioplasty, bursectomy, suprascapular nerve block, manipulation under anesthesia. Apparently, the patient post-operatively continued to have limited motion and pain. A second procedure was done on 9/28/11. This procedure was described as a manipulation under anesthesia and a suprascapular nerve block. Patient apparently continued to have difficulty and surgery was again performed on 4/09/12 which consisted of a manipulation under anesthesia and bursectomy. The patient apparently still has pain and limited motion. It would be my opinion if the amount of very considerable medical involvement described above was not successful, I have no optimism that another procedure would be. She's had multiple surgical procedures and for whatever reason has not done well. In my opinion, further medical procedures of the same type would not be of further benefit.

DESCRIPTION AND SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION

ACOEM-AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL
MEDICINE UM KNOWLEDGE BASE

AHCPR-AGENCY FOR HEALTH CARE RESEARCH & QUALITY GUIDELINES

DWC-DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

INTERQUAL CRITERIA

**MEDICAL JUDGEMENT, CLINICAL EXPERIENCE & EXPERTISE IN ACCORDANCE WITH
ACCEPTED MEDICAL STANDARDS X**

MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

MILLIMAN CARE GUIDELINES

ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES X

PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR

TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE
PARAMETERS

TEXAS TACADA GUIDELINES

TMF SCREENING CRITERIA MANUAL

PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE
DESCRIPTION)

OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES
(PROVIDE DESCRIPTION)